The Florida Conference of The United Methodist Church

Schedule of Benefits Summary

Choice Plus Plan

UnitedHealthcare and The Florida Conference of the United Methodist Church want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using **www.myuhc.com®.**
- Researching health information: Find resources by calling NurseLine® or by logging on to www.myuhc.com.
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network, or when you have coverage or benefit questions.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	**$750** per year	**$1,500** per year
Family Deductible	**$1,500** per year	**$3,000** per year
• Member Copayments do not accumulate towards the Deductible.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	**$3,000** per year	**$6,700** per year
Family Out-of-Pocket Maximum	**$6,000** per year	**$13,500** per year
• The Out-of-Pocket Maximum includes the Annual Deductible		
• Member Copayments do not accumulate towards the Out-of Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met.	70% after Deductible has been met.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Lifetime Maximum Benefit		
The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan.	No Maximum	No Maximum
Prescription Drug Benefits		
Prescription drug benefits are shown under separate cover.		

Information on Benefit Limits

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.
- When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
Ground Ambulance Service	80% after Deductible has been met.	80% after Network Deductible has been met.
Air Ambulance Service	80% after Deductible has been met.	80% after Network Deductible has been met.
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Pre-service Notification is required.	*Pre-service Notification is required.*
Congenital Heart Disease (CHD) Surgeries		
Inpatient Hospital:	$250 Copayment per day, Maximum 3 days.	70% after Deductible has been met.
Outpatient Surgery:	80% after Deductible has been met.	Benefits are limited to $30,000 per surgery *Pre-service Notification is required*.
Dental Services – Accident Only		
Benefits are limited as follows: $3,000 maximum per year $900 maximum per tooth	80% after Deductible has been met.	70% after Deductible has been met.
	Pre-service Notification is required.	*Pre-service Notification is required.*
Diabetes Services		
Diabetes Self Management and Training	80% after Deductible has been met.	70% after Deductible has been met.
Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment [and in the Prescription Drug Section] of the SPD.	
	Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000	*Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000*
Durable Medical Equipment (DME)		
Benefits are limited as follows: Limits do not apply to Durable Medical Equipment classified as diabetic equipment or supplies.	80% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required for Durable Medical Equipment in excess of $1,000.*

Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after you pay a **$150** Copayment per visit *Pre-service Notification is required if results in an Inpatient Stay.*	100% after you pay a **$150** Copayment per visit *Pre-service Notification is required if results in an Inpatient Stay.*
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required.*
Hospice Care		
Network and Non-Network benefits are Limited to 360 days during the entire period a covered person is covered under the policy.	80% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required for Inpatient stays.*
Hospital – Inpatient Stay		
	$250 Copayment per day, Maximum 3 days.	70% after Deductible has been met *Pre-service Notification is required for Inpatient stays.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	Lab - 100% no copay - no deductible X-ray - 100% after you pay a $40 copay per visit .	70% after Deductible has been met.
Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine - Outpatient		
	80% after Deductible has been met.	70% after Deductible has been met.
Mental Health and Substance Abuse Services – Inpatient and Intermediate		
Benefits are limited as follows:	$250 per day, Maximum 3 days.	70% after Deductible has been met.
Mental Health and Substance Abuse Services – Outpatient		
Benefits are limited as follows:	100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
Ostomy Supplies		
	80% after Deductible has been met.	70% after Deductible has been met.
Pharmaceutical Products – Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	80% after Deductible has been met, except if administered in a doctor's office, then 100% after you pay a $20 copayment per visit.	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	70% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a **$25** Copayment per visit.	70% after Deductible has been met
Specialist Physician Office Visit	100% after you pay a **$40** Copayment per visit.	70% after Deductible has been met.
In addition to the visit Copayment, the applicable Copayments or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine, Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.		
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a **$25** copayment will only apply to the initial office visit.	*Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*

Preventive Care Services		
Covered Health Services include but are not limited to: Primary Physician Office Visit Specialist Physician Office Visit Lab, X-Ray or other preventive tests	 100% Deductible does not apply. 100% Deductible does not apply. 100% Deductible does not apply.	 70% after Deductible has been met.
Prosthetic Devices		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.	80% after Deductible has been met.	70% after Deductible has been met.
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	 *Pre-service Notification is required.*
Rehabilitation Services – Outpatient Therapy		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of chiropractic treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy	100% after you pay a **$25** Copayment per visit.	70% after Deductible has been met. *Pre-service Notification is required for certain services.*
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	$250 Copayment per day, Maximum 3 days.	70% after Deductible has been met. *Pre-service Notification is required.*
Spinal Treatment		
Benefit limited to one visit and treatment per day – 24 visits per calendar year combined.	100% after you pay a **$40** Copayment per visit.	70% after Deductible has been met.
Surgery – Outpatient		
	80% after Deductible has been met.	70% after Deductible has been met.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	80% after Deductible has been met.	70% after Deductible has been met. Pre-service Notification is required for certain services

Transplantation Services		
	80% after Deductible has been met. For Network Benefits, services must be received at a Designated Facility. *Pre-service Notification is required.*	Non-Network Benefits are not available. *Pre-service Notification is required.*
Urgent Care Center Services		
	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met
> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.		
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a **$25** Copayment per visit.	70% after Deductible has been met. Eye exams for refractive error are not covered.

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Treatment of congenitally missing malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophogeal voice prosthetics.

Oral appliances for snoring. Repair to prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misues, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

The exclusions listed below apply to the medical portion of the plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the plan. See the SPD for coverage details and exclusions.

Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

MEDICAL EXCLUSIONS CONTINUED

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes; shoe orthotics; lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.
- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and the replacement of lost or stolen Durable Medical Equipment.

Tubings, nasal cannulas, connectors and masks, [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD.

MEDICAL EXCLUSIONS CONTINUED

Mental Health / Substance Abuse

Services performed in connection with conditions not classified in the current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.*

Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Administrator. Services utilizing methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements ,unless authorized by the Mental Health/Substance Abuse Administrator; Routine use of psychological testing without specific authorization; pastoral counseling. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with:

- Prevailing national standards of clinical practice for the treatment of such conditions.
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time.

The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical educational services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and the other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

MEDICAL EXCLUSIONS CONTINUED

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women’s Health and Cancer Right’s Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Wigs regardless of the reason for the hair loss.

MEDICAL EXCLUSIONS CONTINUED

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders.

Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of the obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is

Providers cont.

operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization and voluntary sterilization.

MEDICAL EXCLUSIONS CONTINUED

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true; no skilled services are identified; skilled nursing resources are available in the facility, the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Private duty nursing received on an inpatient basis. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and transplants that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants; and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

MEDICAL EXCLUSIONS CONTINUED

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy.